NOTICE: This form must be printed on 8 1/2" x 14" paper

NEW JERSEY STATE HEALTH BENEFITS PROGRAM COBRA APPLICATION

HC-0070-0904

1. APPLICANT INFORMATION-This section must be filled out completely. Please print or type.

Social Security Number ___ - ___ - ____ Last Name _____ Title (Jr., Sr., etc.) ___

First Name _____ MI ___

Street Address (Include Apartment #) _____

City _____ State ___ ZIP Code + 4 _____ - ____

Date of Birth (mm/dd/yy) ____ Gender (M/F) ___ Relationship to Employee _____

Status (Check One)

☐ -Single ☐ -Married ☐ -Domestic Partnership ☐ -Divorced ☐ -Widowed

(Area Code) ___ Home Telephone Number ___ - ____

2. CHANGE INFORMATION (if applicable)

Type ☐ Open Enrollment

☐ Special Enrollment

☐ Status Change (Indicate reason below)

Moved Out of Coverage Area (Date of Move) _____

Add Spouse (Date of Event) _____
(Attach Marriage Certificate)

Add Domestic Partner (Date of Event) _____
(Attach Certificate of Domestic Partnership)

Add Dependent Child ☐ Birth ☐ Adoption/Guardianship (Proof Required)

(Date of Event) _____

Other (Specify) _____

DIVISION USE ONLY

Effective Dates: Event Reason:

H _____ _____ _____

P _____ _____ _____

D _____ _____ _____

V _____ _____ _____

Location # ____ Term (mos) ____

Note: A Domestic Partner is defined for eligibility in the SHBP, by Chapter 246, P.L. 2003, as a person of the same gender to whom you have entered into a domestic partnership and received a *Certificate of Domestic Partnership* from the State of New Jersey. If covering a Domestic Partner as a dependent, you must attach a photocopy of the *Certificate of Domestic Partnership* to this application.

3. EMPLOYEE INFORMATION (if different from applicant)

Social Security Number ___ - ___ - ____

Last Name _____

First Name _____

Date of Birth (mm/dd/yy) ____

4. COVERAGE ELECTION - Select the coverage desired and indicate with an **X** in the appropriate box.

TYPE OF COVERAGE	Single	Member & Spouse	Member & Domestic Partner	Parent & Child(ren)	Family
Health: Traditional					
Health: NJ PLUS					
Health: HMO					
Dental Expense Plan					
Dental Plan Organization					
State Prescription Drug Coverage					
Vision Care (State Only)					

5. HEALTH PROVIDER INFORMATION FOR APPLICANT

a. Name of HMO Plan _____

b. Your NJ PLUS or HMO Physician ID # ____

c. Name of DPO _____

d. Your DPO Dental Provider Name and Address _____

_____

Note: Your local/educational employer must have elected to provide the SHBP Group Dental Program to you as a separate dental benefit to be eligible for this coverage. If you are eligible for dental coverage through another employer provided plan, do not complete this application.

Note: Your local/educational employer must have elected to provide the SHBP Employee Prescription Drug Plan to you as a separate prescription drug benefit to be eligible for this coverage. If you are eligible for prescription drug coverage through another employer provided plan, or if your employer does not provide any separate drug coverage, your SHBP medical plan will include a prescription drug benefit.

6. DEPENDENT INFORMATION - List all eligible dependents you wish to enroll for coverage. Use a separate page for additional dependents.

☐ Spouse ☐ Domestic Partner / Children	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's NJ PLUS or HMO Primary Care Physician ID#	Name of Dependent's Dentist or ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions

7. ☐ **SSA DISABILITY EXTENSION** — Check this box if you have an approved Social Security Administration Disability and wish your COBRA term extended to up to 29 months. Attach a copy of the Social Security Administration Disability approval letter.

8. I certify that all the information supplied on this form is true to the best of my knowledge. I hereby make application to extend my group insurance coverage under the terms of the program. I understand that my coverage under COBRA will be continuous from the date benefits end. I authorize the Division of Pensions and Benefits to bill me for monthly premium payments and further agree to make further payments in a timely fashion. I understand this COBRA coverage will terminate without notice if payment is not made on time. I understand that if I waive my right to coverage at this time, enrollment is not normally permissible at a later date. I also understand that there is no guarantee of continuous participation by medical or dental service providers, either doctors, dentists, or facilities in the NJ PLUS, HMO, or DPO plans. If my physician, dentist, or medical/dental center terminates participation in my selected plan, I must elect another doctor/dentist or medical/dental center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, dentist, or health or dental care provider to furnish my medical or dental plan or its assignee with such medical or dental information about myself or my covered dependents as the assignee may require. I agree to notify the COBRA Administrator if I or any of my covered dependents become covered under another group health or dental plan or become entitled to Medicare after I elect coverage under COBRA.

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

Applicant's Signature _____ Date Completed _____

DO NOT SEND PAYMENT WITH APPLICATION — YOU WILL BE BILLED

HC-0070-0904

Clear Page

— COBRA NOTICE —
CONTINUATION OF STATE HEALTH BENEFITS PROGRAM COVERAGE UNDER COBRA

This page is to be completed by Employer (Please print or type)

a. To the Family of —

_____

_____

_____

_____

b. SS#: _____

c. Notice Date: _____

d. Employer Name: _____

e. Emp ID #: _____

f. EMPLOYEE TYPE:

☐ 10 month

☐ 12 month

Dear Employee and/or Dependent(s):

Your health care coverage under the State Health Benefits Program (SHBP) terminates as shown below because of a change in employment status or dependent eligibility. The reason for the loss of coverage, the type(s) of coverage lost and the last day of coverage(s) are shown in the notice below. Under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you are entitled to continue your medical benefits with the group program for a limited time.

If you wish to continue coverage under the provisions of COBRA, you must enroll at this time. Otherwise, you will lose coverage and you cannot enroll later.

You may continue the group coverage(s) shown below under COBRA, at your own expense, for the time period shown in the COBRA Continuation Term or until one of the following conditions occur: (1) you voluntarily cancel your coverage; (2) you become covered under MEDICARE or another group plan after you elect COBRA coverage (Note: Exceptions are made if your other group has a pre-existing condition clause that affects you); (3) you fail to pay your premiums in a timely manner; or (4) your employer drops out of the State Health Benefits Program.

If you are retiring, you may be eligible for lifetime health and prescription drug coverage through the Retired Group of the State Health Benefits Program. Consult your employer or the Division of Pensions and Benefits **PRIOR** to enrolling for health and prescription drug benefits under COBRA.

In considering whether to elect continuation of coverage under COBRA, you should take into account that you cannot enroll at a later date and that a failure to continue your group health coverage may affect your future rights under federal law. Please refer to Fact Sheet #30, *Continuation of Coverage Under COBRA,* for more information on your election of COBRA coverage.

If you wish to continue your group coverage under the provisions of COBRA, complete the application on the reverse side and send it to the **Division of Pensions and Benefits, P.O. Box 299, Trenton, NJ, 08625-0299**. If you elect to continue coverage, you will be enrolled so you have no break in coverage. After your application is processed (allow up to three weeks), you will be sent a letter of confirmation of enrollment indicating the beginning date(s) of your COBRA coverage(s) and the length of your COBRA eligibility. The SHBP will send you an invoice of premiums that are due for your coverage (this may include retroactive premiums).

You should make a copy of this notice and your completed application for your records prior to mailing the originals to the Division of Pensions and Benefits. After mailing, if you do not receive the confirmation of enrollment identified in the preceding paragraph, you should contact the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524 or by e-mail at *pensions.nj@treas.state.nj.us*

COBRA EVENT: (check one)

- ☐ Retirement
- ☐ Privatization
- ☐ Termination other than Retirement/Privatization
- ☐ Reduction in Hours
- ☐ Leave of Absence
  - — State/Federal Family Leave
  - — Other
- ☐ Death
- ☐ Divorce or Separation/Disolution of Domestic Partnership
- ☐ Dependent ineligibility
  - — Over age 23
  - — Marriage
  - — Moved out
- ☐ Medicare Entitlement

CURRENT COVERAGE TYPE: (check one)

HEALTH PLAN			NON-CORE PLAN		
Traditional	HMO	NJ PLUS	Dental	Rx	Vision (State Only)
☐ S ☐ M&S/DP ☐ P&C ☐ F	☐ S ☐ M&S/DP ☐ P&C ☐ F	☐ S ☐ M&S/DP ☐ P&C ☐ F	☐ S ☐ M&S/DP ☐ P&C ☐ F	☐ S ☐ M&S/DP ☐ P&C ☐ F	☐ S ☐ M&S/DP ☐ P&C ☐ F

S = Single M&S/DP = Member and Spouse or Domestic Partner

P&C = Parent and Child F = Family

HMO Plan _____

Dental Plan _____

DATE OF COBRA EVENT: _____

CONTINUATION TERM: _____ months of COBRA eligibility.

LAST DATE OF COVERAGE (Month/Date/Year): Health _____ Dental _____ Rx _____ Vision _____

EMPLOYER CONTACT AND TELEPHONE #: _____

The Certifying Officer must sign here after printing the completed form.

Signature of Certifying Officer

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE OR THE LAST DATE OF COVERAGE, WHICHEVER IS LATER, TO ELECT COVERAGE UNDER COBRA. FAILURE TO RESPOND WITHIN THIS TIME PERIOD IS CONSIDERED A DECISION NOT TO CONTINUE COVERAGE.